Welfare in the Mediterranean Countries

Republic of Turkey

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Health reforms

Introduction- Country brief

Turkey is located between two continents, Asia and Europe, a historical country where the two cultures and ways of life meet and blend. In the Turkish territory there is Anatolia, the birthplace of many great civilizations, which have always been a bridge for commerce and a gateway between cultures because of its land connections to three continents and the sea surrounding it on three sides. Turkey, including lakes, covers 814 578 km2 and is bordered by Georgia and Armenia, the Islamic Republic of Iran, Iraq, Syria, Greece and Bulgaria. Turkey’s coasts are bordered by the Mediterranean Sea along the west coast of Turkey, facing Greece, and in the northern part of the Aegean, the Dardanelles give passage to the Sea of Marmara which then opens into the Black Sea through the Bosphorus which separates the European side from the Asian side of Turkey’s most important city: Istanbul. After the First World War the Ottoman Empire collapsed and so the founding father of the Republic, Kemal Atatürk, established the Republic of Turkey on 29 October 1923.

The importance of the Atatürk reforms was the transformation of his military power and leadership into a general leadership in the fields of economics, political science, manufacturing and engineering. There are two important dates in the creation of the Republic of Turkey. The first one is linked to 1945 when Turkey joined the United Nations, and the second one is linked to 1952 when Turkey became a member of the North Atlantic Treaty Organization (NATO). During this period the most important problems of the new Republic were economic and this led to military coups on 27 May 1960, 12 March 1970 and 12 September 1980.

During the military coup of 1960, one of the most important reforms was passed, leading to the introduction of a new constitution, which was approved by the population through a referendum on 9 July 1961 with a substantial majority (61.5%, with a turnout of 81%), and it introduced some important reforms which are important still now. The Constitution was the most important of these. It was long and detailed and introduced, for the first time, the separation of powers. The legislative power was divided in two chambers: the Grand National Assembly and the Republican Senate. The Executive power was given to the President and the Council of Ministers and their actions are free in the limits delineated by law. The Judicial power was to be exercised in all the Nation in independent tribunals and it was introduced a Constitutional Court to ensure that laws were compatible with the

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1 For further details see Valeria Talbot, Un modello turco per il Grande Medio Oriente?, ISPI, Policy Brief, n.5, 2004.
constitution. The Constitution established that government had to provide to several social reforms and also for the basics of rights and freedom was also detailed and it was going on until 1982.

The constitution of 1982 was approved by a majority near to 100% in a public referendum (91%, with a turnout of around 90%). This new constitution introduced several reforms also in the freedom rights in the way to restrict them. This allowed to the governments to administrate the state more easily.

Now Turkey is a democratic secular, social and legal state, it is a republic with unconditional and unrestricted sovereignty. People have the sovereignty and they exercise it directly through elections, and indirectly through the authorized branches within the constitutional framework.

Now the Republic of Turkey has three branches which exercise power: The legislative, executive and judicial branches.

1. Turkey’s parliament, the Grand National Assembly, operates with 550 elected members.
2. The executive branch is formed by the President of the Council of Ministers and the Council of Ministers.
3. The judicial branch is structured in independent courts all over the country and supreme judiciary organs which exercise judicial power.
4. The President of the Republic of Turkey is the head of state and as such represents the Republic of Turkey and the unity of the Turkish nation.
5. The Council of Ministers is formed by the Prime Minister and various other ministers.
6. The state is organized centrally and locally. The central administration, excluding the legislative and the judicial branches, comprises the Prime Minister’s office and the various ministries. For administrative purposes, Turkey is divided into 81 provinces and 900 districts. Population centres are designated as cities, towns or villages, depending on the size of their population. The organization and functions of the administration are based on the principles of centralization and local administration, and regulated by law. The Ministry of Internal Affairs appoints the provincial governor and the district administrator which represents the state at the provincial and district levels, where they coordinate and administer state policy. Locally elected assemblies include the general provincial assembly, the municipal assembly and the village council of elders. The mayors of cities, district centres and towns are also directly elected, as are village heads.

1. Health indicators
Before assessing health provision in Turkey it is important to analyze the demographic and epidemiological features of The Turkish Republic. Turkey with its 67.85 million population is one of the most crowded countries in the world. There is a young population as a result of high fertility and growing rates in the past. Now 30% of the population is below the age of 15 and 11% is below the age of 5. More than 17.8 million women (38% of population) are in their fertile phase (ages 15-49). In 1970 fertility was 5 children per woman and at the beginning of the 90s it was 3 per woman. To assess the problems in Turkey we must consider that in general Turkey does not have a good level both absolutely, and when compared with the other countries with the some level of births. All the sector has problems both in maternal mortality and in infant mortality.

High infant and adult mortality rates demonstrate that the health status of Turkey is poor compared to other countries with similar per person income levels. Infant mortality per 1000 live births in Turkey was 36.8, compared to 9.6 in Poland, 5.6 in the Czech Republic. There are significant regional variations in infant mortality. Under-five mortality is also high, at 52.1 per 1000 in 1999; again, the rate varies according to region. In 1999, the base birth rate was 21.4 per 1000, the base death rate 6.8 per 1000, and the annual population growth rate was 1.5%.

According to statistics from the World Health Organization (WHO), the maternal mortality rate in 1998 was 130 deaths per 100 000 live births, although other sources quote a much higher rate of 180. The latest estimates put life expectancy in Turkey at 71 years for women and 67 years for men. This is well below the 1998 EU average life expectancy at birth of 80.5 years for women and 74.4 for men. It is also lower than the 1999 average for all of Europe of 77.6 years for women and 69.5 years for men. In spite of the rapid improvements in the near past, Turkey is still behind of the most of the middle-income countries in terms of health-levels. Less than two thirds of all mothers receive pre-natal care and the full dosage tetanus injection can be given to less than one third of them. On average, a doctor is present in only 2 of the 5 births (40%). An effect of the big economic problems of Turkey is that 11.6% of the women in the poorest group give birth under the control of doctor and in the richest group this percentage grows until 72.3%.

There are also regional variations within Turkey in life expectancy at birth and the differences in health indicators between rural and urban areas. But we must consider that the Turkey’s health information systems are poor, and so also the information about the exact prevalence and incidence rates for various diseases and causes of death cannot be determined.
Fig. 1 Main causes of death by age

Something is changing because the frequency and the importance of infectious diseases are decreasing and a rise in epidemiological to chronic diseases is observed. The analysis of health in Turkey must consider that the population live in cities and projections performed show that the urban ratio will reach to 80% in the near future. The rapid urbanization period that Turkey has experienced has caused many problems in the infrastructures and town planning services and in the delivery of the health services. It is enough to consider that if Turkey is 17th in the global scale as an economic power, but is 86th in the human development index prepared according to social indicators involving health and education. Inequality in health status is widespread.

Infant mortality is a good indicator of the unequal distribution of health and unequal access to preventive health care services. There are several differences in neonatal, post-neonatal and infant mortality rates between western and eastern Turkey and between rural and urban areas. While the quality of epidemiological data in Turkey is questionable, particularly for rural areas, it seems clear that the most important causes of mortality among children aged 1–4 years old are infectious diseases and their complications, mostly associated with malnutrition. Turkey’s current vaccination schedule is based on WHO criteria. Vaccination rates vary among different regions and settings. Other measures such as the correct implementation of the schedule also vary substantially. Vaccination rates are higher in the urban and western regions of Turkey and are positively correlated with the educational status of the mother.

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1.1 Organizational structure of the health care system

Turkey’s health care system is fragmented and centralized and it also includes a complex structure - the consequence of historical developments. Today in Turkey there are a lot of organizations which provide health care with different forms, structures, objectives and achievements. The Health-organizations are public, quasi-public, private and philanthropic organizations, but relations among them are not well structured or regulated. There are two main ways to finance the health services: one is linked to the public resources and the other one is to finance through the people who demand the health services. Turkey has mixed structures, in fact health expenditure has three main sources:

1. state budget from the government (through the Ministry of Finance), funded by tax revenue and allocated to the Ministry of Health, the Ministry of Defence, university hospitals, other public agencies and the health care expenditure of active civil servants;
2. social security institutions (the Social Insurance Organization (SSK), the Social Insurance Agency of Merchants, Artisans and the Self-employed (Bag-Kur) and the Government Employees’ Retirement Fund (GERF)), in this case the financing comes from the contributions obtained from members;
3. people’s personal spending, in the form of directly payments to the doctors and institutions.

In Turkey there are a lot of agencies directly or indirectly involved in the Health care system according to whether they formulate policy, have administrative jurisdiction over the delivery of health care, provide it or finance it. It is important to remember that without a national health account system it is impossible to record and to monitor the health numbers and to analyze the use of the resources in health system in Turkey. We can observe at least that:
1. Sources for health in Turkey are less than in the other countries and there is, as a result of fragmentation, an inefficient way to use it;
2. There are a lot of differences in the countries, because not everyone is protected by an insurance on health, and among the different social

6 For further details see Adaman, F., Study on the social protection systems in the 13 applicant countries: Turkey country report. 2nd draft, Brussels, European Commission, 2002.
security institutions there a lot of differences in the way to assure the services;

3. It is not possible to know exactly the number of people insured now. For this reason it is impossible to calculate health expenditure per person;

4. The personal payments by the public is not monitored and in this situation it is not possible to know the exact health expenditure for and to plan for the future.

All these problems show that health financing is complex and uncontrolled, and this situation increases the burden on the budget indirectly. This mechanism increases the sources used in this sector more than the sector itself needs. This is the reason why the health sector is always in deficit as we can see in the table below (fig. 2).7

![Fig.2](image)

1.2 Planning, regulation and management

In Turkey the responsibilities for planning, coordinating, financially supporting and developing health institutions to provide equitable, high quality and effective health services is divided among the Ministry of Health, the military, parliamentary commissions and others.8

The Grand National Assembly is responsible for approving the five-year development plans submitted by the State Planning Organization, which reports directly to the office of the Prime Minister. The State Planning Organization has two separate planning roles. The first one is to do a strategic five year plan and it is also responsible for investment appraisal and planning, and must approve any new capital investment in health care. Unfortunately, there isn’t good coordination between the strategic planning and the investment roles because the strategic targets are not defined clearly. At the same time it is important to observe that the procedure for investment planning is more clearly established and more detailed, and the influence of

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7 All data by World Health Organization (WHO) Regional Office for Europe. European health for all database, Copenhagen, 2002 in http://hfadb.who.dk/hfa (accessed June 2004);

the Organization is stronger, as it has the power to veto capital investment for statutory health care providers, whereas its role in implementing strategic plans is restricted to monitoring only.

The Ministry of Health sets the policy objectives for the health sector or for planning the delivery of health care through its hospitals and other health facilities. Once the government has approved the budget for health, the Ministry of Health, through the Research, Planning and Coordination Unit allocates resources and coordinates budget-setting and budget allocations and it also monitors the implementation, by the ministry’s general directorates and departments, of specific measures related to the annual programmes of the five-year plans. The Ministry of Health central level provides for the health policy and the health services. At the provincial level the health services are guaranteed by the provincial health directorates accountable to provincial governors. At the top of the ministry is the Minister of Health, supported by a private secretary.

It is important to remember that the lower levels of the Ministry of Health hierarchy consists of general directorates and departments responsible for delivering health services. The provincial health directorates administer the health services provided by the Ministry of Health at the provincial level. Each of the 81 provinces has a health directorate led by a director who is accountable to the governor of the province. The directorates’ administrative responsibilities are primarily personnel and estate management. They also make technical decisions pertaining to health care delivery, such as the scope and volume of health services. Units that provide health care or have health care-related functions at the provincial level consist of: 1) health centres; 2) health posts, mainly in rural areas; 3) mother and child health and family planning centres; 4) tuberculosis dispensaries; 5) hospital; 6) public health laboratories.

In general we can observe that there is a clear delineation of health service responsibilities in defined areas but, in reality, all the areas have common characteristics in the responsibilities which can confuse the coordination of the Ministry’s activity. This exiting level of coordination between all the actors of the health services doesn’t appear sufficient to guarantee a good distribution of the resources to each area of service delivery. On the other side the Ministry has a lot of difficulty in controlling the results of the provincial governors, which take instructions from many general directorates and departments. It is also important to consider the role of the Council of Higher Education, which is responsible for university hospitals; they work as autonomous agencies and aren’t under the control of the central powers and authority. Individual hospitals are not considered in the planning cycles.
The health sector in Turkey is characterized by more actors than it needs. The following bodies are involved in the health field: 1) The Ministry of Finance administers the budget which is the main funding source for health services provided by the Ministry of Health, the Ministry of Defence, university hospitals and other public institutions in Turkey. Also the General Directorate of Budget and Fiscal Control of Ministry of Health is under the jurisdiction of the Ministry of Finance. The GERF contribution rates and benefits are determined by the Ministry of Finance; 2) The Ministry of Defence has its own health care infrastructure which work only for military personnel and their dependants; 3) The Council of Higher Education is responsible for university hospital which are increased a lot in the last 30 years. University hospitals, directed by a chief doctor and able to give primary, secondary and tertiary care; 4) The Ministry of Labour and Social Security has jurisdiction over the SSK, which is the second largest provider of health care in Turkey; 5) The Ministry of National Education, the Ministry of Internal Affairs, the postal service and the railways have established their own hospitals and polyclinics. Near the state providers we find in Turkey three main social security institutions: 1) SSK, the insurance scheme for private sector employees and blue-collar public sector employees; 2) Bag-Kur, the insurance scheme for

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9 For further details Health system in Turkey, Ministry of health of Republic Turkey, Ankara 2002.
Merchants, Artisans and the Self-employed; 3) GERF, which insures retired civil servants.

1.3 The private sector

At the beginning of the ‘80s, there were only 80 private hospitals, with not more than 50 beds and they were established by and large, by foreigners. The private hospitals in 2001 were more than 250 in number. Their role is fundamental because they appear able to answer the needs of the people. For these reasons the social security institutions, i.e. SSK, are purchasing some health services from private hospitals, like cardiovascular surgical services and in the last months also cataract surgery.

The public salaries for the doctors are low and therefore, over the years, many doctors have created their private work after office hours. People believe it is better to go to private practitioners because he gives a patient more attention. People pay for services out of pocket, regardless of their membership of any social insurance organization. Patients with voluntary (private) health insurance might receive partial reimbursement from their insurance companies. Since the 1990s, the development of private polyclinics has grown and now we can observe the presence, in the big cities, of a lot of diagnostic centres near polyclinic centres.

As Turkey has no self-dispensing doctors, private pharmacists have a monopoly on the sale of all outpatient drugs. Health centres also provide medicines for specific programmes and for areas without private pharmacies. Social security institutions pay individual private pharmacies directly for the prescriptions of their members.

In general private health care is neither legally recognized nor permitted to practise in Turkey. Some people do practise as dentists and chiropractors without any official training, while others, mainly from the newly independent states of the former Soviet Union and countries in east Asia, practise alternative medicine. The exact number of these providers is not known.

In Turkey we find also some philanthropic providers of health care, like Red Crescent, its main function is to provide aid in natural and war-related catastrophes but it also provides several others health services. There are also some foundations that have been present in Turkey since the Ottoman Empire but they are playing a new role after the law changes in the 1990s, and they offer health care services especially in the fields of family planning issues. There are also numerous foundations working on specific diseases such as diabetes, cancer, phenylketonuria and AIDS. Most public hospitals, including the university hospitals, have created foundations (quasi-public non-profit institutions with tax-exempt status) to bypass cumbersome bureaucratic rules for recruiting personnel and spending their own revenue. However, some of
these foundations may have developed into instruments to further private interests rather than public services.

There is also the Turkish Medical Association and other professional organizations which are not very well organized but in future, their responsibilities might expand to include the adaptation of clinical practice to European norms, at least in some areas of specialization.\textsuperscript{10}

\textbf{1.4 Decentralization as a central point for a reform}

From this examination of the health system in Turkey it is clear that Turkey is a centralized and fragmented country. Decision-making and implementation bodies vary in form, structure, objectives and achievements the Ministry of Health is strongly centralized Even though each province has its own provincial health directorate structured to solve a wide range of health problems, local decision-making is not encouraged. Dealing with local health problems that require local solutions is therefore extremely difficult and becomes a bureaucratic process, since the central organization must be informed of or consulted in every decision.

In this last few years Turkey has tried to pass several health system reforms through national and international partnerships.\textsuperscript{11} In 2003 the Turkish government appointed the health transformation programme with these aims: 1) to organize; 2) to provide financing; 3) and to deliver the health services in an effective, productive and equal way.

To create efficiency means that Turkey must develop effective policies with the objective of preventing diseases and to analyze the epidemiological indicators. The second important step of the programme is to create productivity, reducing the costs while producing more services. The Health programme must again organize human resources, management of materials, rational drug use, health administration preventive medicine practices. Equality is the most important target fixed by the programme and it is based on the simple principle of guaranteeing access to the health services by all citizens. Citizens must give their contribution to the state according to the extent of their financial powers. The scope of equality includes decreasing the gaps in access to health services, and health indicators among different social groups, between rural and urban areas and between east and west of the Country.


\textsuperscript{11} For further details see Ministry of health of Republic Turkey, Transformation in Health, Ankara 2003, December.
Before speaking about the specific objectives of the Health Programme it is important to clarify some principles of the programme, which are: 1) **Human centrism**. It concerns the central role of the citizen in the programme. The citizen’s demand and hopes must be considered as the most important thing in the planning; 2) **Sustainability**. It means that the changes must be planned considering the financial resources; 3) **Continuous quality improvement**. It means that the health systems always reviews itself, getting away the insufficiencies experiences and valuing the successes. 4) **Participation**. It is important to hear each actor in the procedure (stakeholders, citizens, doctors, etc.); 5) **Reconcilement**. It creating a democratic way to deliver services, taking into consideration the different interests of the various units involved in the process and to find the common points; 6) **Volunteerism**. It is the only way to include all the society in the Programme for Health without making any distinctions between individuals and institutions; 7) **Division of power**. It is important to separate the four important functions, providing the finance of health services, making plans, undertaking control and producing service. Only in this way it is possible to avoid conflicts. 8) **Decentralization**. It is important to eliminate the hierarchy between the central and provincial power. Each unit must be independent in using resources but must respect the objectives of health as defined by the government. 9) **Competition in service**. It signifies that it is important to transfer the health services from a monopoly to a competitive market. In this way the costs will decrease and benefits and quality will grew.

### 1.5.1. The eight components of the Health Transformation Programme

The Health Transformation Programme consists of 8 components, which have been formed to cover the sector with all its dimensions. Each component is matched with other components and covers the solutions appropriate for the programme. The Ministry of Health can develop policies, define standards, make controls and steering efforts in order to use efficiently resources for health. The Ministry of Health must take the Constitution role of planner and controller on the health system. In order to achieve this objective it is necessary to: 1) re-organize its structure and to define new mission and tasks in the field of human resources, personnel management, distribution of resources and material management; 2) review the structure of financing health the rural areas creating more active leadership; 3) reorganize the functions, mission, and sector policies, to promote and modernize central and local health services; 3) to develop a management model to encourage the management to take decision and responsibilities of their choices; to develop, implement and control education programme in

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health. It will be important, at the same time, to develop preventive services and strengthen primary health services. In the long period it will be important to control the services through quality control system.

**General Health Insurance.** An insurance model which is able to guarantee everyone’s needs in health services; citizens will contribute to the insurance according their own financial capacity. In this way there will be more respect for Article 56 of the constitution. Today SSK, BAGKUR, and the Social Security organization for civil servants are already working towards these goals. In reality it will be important to separate the health services from the retirement insurance. They must implement a standard way to deliver services. It is not possible that services and health care are different in the country when the citizens pay the same fees all over the country. It is important to eliminate the financial relations between the patient and the doctor, this relation should not be based on money. It is important: 1) to identify the poor people who cannot pay the insurance or the health expenses. In this way the public power can provide to pay a premium for this people; 2) the health premium pool will be separated from the other branches of social security and its own balances will be set up; 3) to check resources and how they are spent in the health field.

There are some really important organizational points that must be achieved in General health Insurance with the coordination with the Ministry of Labour and social security: 1) each Turkish citizens will be covered and single number will be given to every citizen; 2) health insurance will be separated from other insurance systems; 3) Health Institutions will not check whether the premium has been paid or not because the Insurance institutions will be responsible for the premium payment.

**Health systems easily accessible and friendly.** There are a lot of differences between the East and West of Turkey and between rural and urban areas. For this reason the Health transformation program encourages some changes, but slowly because it is not possible in the space of a few years to completely change some areas, ideas and ways of life.

First of all it must strengthen primary health care services and family medicine. It will be important to develop health care service in the rural areas. To develop the health system more efficiently it will be important to have financial and administrative autonomy. If the hospitals make contracts with insurance institutions all hospitals could deliver services to the citizens. Autonomy will be provided to all hospitals of the Ministry of Health and Social Insurance Institutions in terms of both financing and administration and also for the procurement of necessary input for producing and managing health services. This system will enhance the productivity of the hospitals.

Each hospital will be responsible for its own management decisions, service quality and productivity.
Health manpower equipped with knowledge and competence and working with high motivation. Human resources are a central point of the reform because if they have success in transforming the health care systems, it will be because they have new motivation and competences that are able to change the system. In line with European law, and with the cooperation with the universities, a new education programme will be created for the specialization of family physicians who will work in the primary care area. The other main tasks are to make Turkish society more aware of dental health, to enable training and to provide a structure aimed at treatment with preventive medicine efforts. At the same time the transformation will be made in arrangements for improving nursing training to international level and for improving nursing service as a scientific discipline. Local governments, non governmental organizations and labour associations should be involved in the system effectively. Decentralized human resource planning and management skill will be formed and participation of health administrations into human resources planning effectively will be provided.

Education and science institutions supporting the system. It will be important to use people who have knowledge and skill in public health policy, management, economy and planning to reorganize the health sector. It will be important to establish a new institutional structure that will reorganize education hospitals, plan the current specialized education in medicine, make standardization and control. These practises will be reunited to an academic structure under Health Academy or Health Specialization Institution.

Quality and accreditation for qualified and effective health service. Until now the problem of quality is not valued highly enough in Turkey, but service providers and financial providers have begun to pay attention to this important problem. “The National Quality and Accreditation Institution”, soon to be established, will organize the authorizations, certifications and accreditations of services. A new system will be developed system to measure health outcomes and these measures will be used to formulate performance indicators for health service suppliers.
Institutional structure in the management of rational medicine and equipment. There is a need to create an institutional establishment that will be able to catch up with the international norms on issues of standardizations, authorization and rational use of medicines, equipment and medical devices. First of all we must consider that the expenditure for medicines and pharmaceutical products are very high. The increase in medicine prices doesn’t depend on scientific bases. The people are very sensible to the price of medicines, therefore the health programme prevents a dialogue with the stakeholders, on scientific bases, to solve the problems related to medicines. Today, plastic and electronic infrastructure is very sophisticated in Turkey. These sectors should be encouraged and directed at the investments that will make production for medical technology. The manufacturing will become easier and will enable Turkey to become an exporting country and prevent waste of resources.

Health information system. effective information for the decisions-makers. Turkey suffers the lack of certain data on the health services. There is no correct information on expenditure and costs of health services in Turkey. In the next few years the Health Information System will be established, to form a health inventory, to keep medical reports of individual, to enable flow of information among transfer steps and to collect data on primary health care. The health information system can collect and process sufficient data which can be used for scientific research and studies on the determination of policies relating to health, deciding on the problems and priorities in the health sector, taking measures, planning of sector resources, tasks and investments, and evaluation of delivered health services.

Conclusions

In the last few months the Turkish Government has established some lines of changes to harmonize Turkish law with the European Union Legislation. In the field of health and safety at work, the Council Decision of 19 May 2003 on the Accession Partnership with the Republic of Turkey states that the adoption of a programme for the transposition of the relevant EU legislation shall be completed in the short term, while transposition and implementation of the legislation is put forward as a medium term priority. The implementation of the health and safety legislation also constitutes one of the important aspects of the adoption of the legislation in the field of EU Social Policy.
Therefore, the strengthening of the inspection systems by labour inspectors is put forward as an administrative measure within the medium term priorities of the same chapter in Council Decision of 19 May 2003 on the Accession Partnership with the Republic of Turkey.\(^\text{13}\)

In the schedule above it is possible to find the necessary legislative changes, according to the existing Turkish legislation and responsible Turkish institution.

To achieve the results indicated there are necessary institutional changes that must happen in the respective period of implementation: 1) establishment of regional tele-medicine services in order to ensure the efficient implementation of the Implementing Regulation, adopting Council Directive 92/29/EEC. 2005, IV. Quarter; 2) Recruitment of personnel to be employed in tele-medicine services 2005, IV. Quarter; 3) training of personnel employed in the tele-medicine services 2005, IV. Quarter; 4) provision of equipment for the tele-medicine services 2005, IV. Quarter 5) Administrative regulations for the training of inspectors and trainers who will determine the main training standards for medical and emergency measures 2005, IV. Quarter.

One of the main systems for the protection of public health is surveillance and control of communicable diseases. Harmonizing the current list of communicable diseases for which notification is compulsory with that of European Union, and strengthening the surveillance and control system in this field is deemed necessary. It is also important the participation in the Programme of Community Action in the Field of Public Health (2003-2008)

In the next few years the Health Systems will be financed as shown in the table below:

\(^\text{13}\) Turkey is currently participating in the European Agency for Health and Safety at Work defined in Council Regulations 2062/94 and 1643/95. In addition, participation in the Committee for the Senior Labour Inspectors, mentioned in the Commission Decision 319/95, with observer status will be offered.
In order to follow EU policies and implementation and to provide integration in the field of health, participation in the relevant Community Programme is essential.\textsuperscript{14}

\begin{table}
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\begin{tabular}{|l|c|c|c|c|}
\hline
Requirements & Year & National Budget & EU Resources & Other Resources & Total \\
\hline
\multirow{3}{*}{\textbf{Task 6.1.1 Health and Safety at Work}} & \textbf{I. Investment} & & & & \\
& Setting Up Tele-Medicine System & 2005 & 4,231,000 & 12,752,000 & 17,053,000 \\
\hline
\multirow{9}{*}{\textbf{II. Harmonisation with the EU Legislation and Implementation}} & \textbf{ Personnel} & & & & \\
& 32 doctors, 25 opticians, 73 sanitary officers & 2004-2005 & 167,500 & & 167,500 \\
\hline
& \textbf{ Training} & & & & \\
& - Training on first and emergency aid & 2004-2005 & 75,000 & 225,000 & 300,000 \\
& - Training on sea adaptation & & & & \\
& - Training on first and emergency aid at sea & & & & \\
& - Training on Tele-consultation and visual communication & & & & \\
& - Language Training & & & & \\
\hline
& \textbf{ Consultancy} & & & & \\
& Translation & 2003-2005 & 25,000 & 75,000 & 100,000 \\
\hline
& \textbf{Other} & & & & \\
\hline
& \textbf{Sub Total} & 2003-2005 & 4,518,500 & 13,052,000 & 17,570,500 \\
\hline
\end{tabular}
\caption{Fig. 6}
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\begin{table}
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\begin{tabular}{|l|c|c|c|c|}
\hline
Requirements & Year & National Budget & EU Resources & Other Resources & Total \\
\hline
\multirow{4}{*}{\textbf{Task 6.2.1 Participation in the Network for the Epidemiological Surveillance and Control of Communicable Diseases}} & \textbf{I. Investment} & & & & \\
& (Renovation of PC and Office Equipment) & 2004-2005 & 500,000 & 2,000,000 & 2,500,000 \\
\hline
\multirow{9}{*}{\textbf{II. Harmonisation with the EU Legislation and Implementation}} & \textbf{ Personnel} & & & & \\
& Training & 2004-2005 & 250,000 & 750,000 & 1,000,000 \\
\hline
& \textbf{ Consultancy} & & & & \\
& Translation & 2005 & 2,200 & 7,500 & 10,000 \\
\hline
& \textbf{Other} & & & & \\
\hline
& \textbf{Sub Total} & 2004-2005 & 755,000 & 2,795,000 & 3,550,000 \\
\hline
\end{tabular}
\caption{Fig. 7}
\end{table}

\textsuperscript{14} For further information see, Regular Report on Turkey’s progress towards accession, 2003, European Union.
The Memorandum of Understanding for the Community Programme, which was initiated within the framework of Council Decision No. 1786/2002/EC has been signed and was published in the Official Gazette No. 25053, dated 19 March 2003.

Before the end of 2005 it will be necessary first of all to strengthen the surveillance and control system for communicable diseases, establishing regulations in order to participate in EU networks, training and interpretation. At the same time it will be important to participate in the Programme of Community action in The field of Public Health. the financing requirements (fig. 7). are indicated in the table below.